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ABSTRACT

This practicum designed and implemented a program using art therapy to improve the social competency of elementary-aged children with attention deficit hyperactivity disorder and oppositional/defiant disorder. Students were in a special class for children with severe emotional disturbances. The children met once a week in art therapy sessions either individually or in pairs and were observed in structured and unstructured situations. A combination of art therapy, verbal associations, and role playing were used to help children interpret social cues, generate solutions to social dilemmas, and apply this learning in social settings. Analysis of projective drawings, interviews, and observations suggested that the children improved in the areas of interpreting social cues and generating solutions to social problems. However, application of learned social behaviors was observed only when students were first given a verbal reminder. Appendixes include a letter to parents and samples of students' drawings. (Contains 23 references.) (DB)

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ED 368 120

Promoting Social Competency in Attention Deficit Hyperactivity Disordered Elementary-Aged Children

by

Linda Jo Pfeiffer

Cluster #45

A Practicum II Report presented to the Ed.D. Program in Child and Youth Studies in Partial Fulfillment of the Requirements for the Degree of Doctor of Education

NOVA UNIVERSITY

1993

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PRACTICUM APPROVAL SHEET

This practicum took place as described.

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This practicum report was submitted by Linda Jo Pfeiffer under the direction of the advisor listed below. It was submitted to the Ed.D Program in Child and Youth Studies and approved in parial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

January 6, 1994
Date of Final Approval of Report

Mary W. Staggs Ed.D.
Mary Staggs, Ph.D., Advisor

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Many thanks to my family whose continual support has been so very important to my completion of this project. I would also like to thank Dr. Mary Staggs for her guidance. To the children who participated in this practicum, I owe a special thanks. They helped me laugh and dream and see life a little bit differently each day.

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ABSTRACT

Promoting Social Competency in Attention Deficit Hyperactivity Disordered Elementary-Aged Children. Pfeiffer, Linda J., 1993: Practicum Report, Nova University, Ed.D. Program in Child and Youth Studies. Attention Deficit Hyperactivity Disorder/Social Skills Training in Children/Hyperactivity in School-aged Children/Children and Pro-social Behaviors/Social Development and Emotionally Disturbed Children.

This practicum focused upon the design and implementation of a program to improve the social competency of Attention Deficit Hyperactivity Disordered (ADHD) elementary-aged children with comorbid features of oppositional/defiant disorders who were placed in an educational setting for the severely emotionally disturbed (SED). The children met one time per week in art therapy sessions either individually or in a dyad format and were observed in structured and unstructured activities. This practicum incorporated art therapy, verbal associations, and role playing.

This writer developed a therapeutic program designed to address the social competency of children whose poor social skills hampered their educational progress. The major focus of the program was to help children interpret social cues, generate solutions to social dilemmas, and apply what was learned in social settings.

Analysis of the results obtained from projective drawings, interviews, and observations suggested that the children had improved in the areas of interpreting social cues and generating solutions to social problems. Applying learned social behaviors was observed only when they were first given a verbal reminder.

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CHAPTER I

INTRODUCTION

Description of Community

This writer works in a large, metropolitan community in the southeast. It is one of the largest school districts in the country. The community is multicultural, multi-ethnic, and racially diverse. The largest percentage of the population is Hispanic and newly arrived to America. Throughout the central and southern parts of the county, Spanish, rather than English, is more often heard in stores, restaurants, and in the hallways of the schools.

The population of this community is rapidly growing with people from other countries and citizens from different parts of the United States. The public school system has difficulty keeping pace with the population growth. The schools are filled to capacity. High-school populations in some localities range from 3,000 to over 5,000 students. Some of the elementary schools house over 1,200 students. Portable trailers, used as alternative classrooms, are common sights on the schools' playing fields.

Writer's Work Setting and Role

This writer worked in a self-contained special education program for children labeled severely emotionally disturbed (SED). The program was housed within a regular elementary school. The SED program consisted of approximately 55 children ranging from four to eleven years of age. Many of the children staffed into this program were referred directly from mental health hospitals. Others came from less restrictive special education settings. The children in the program were transported to the school from a large geographical area. However, the majority of the children were Hispanic and ethnically representative of the community as a whole.

The students in the SED program had diagnoses that included, but were not limited to: Pervasive Developmental Disorder, Bipolar Disorder, Depression, Attention Deficit Disorder with Learning Disabilities and/or Conduct Oppositional Disorder, and Childhood Schizophrenia. Many of the children were under psychiatric care and took psychotropic medications such as anti-anxiety medications, anti-depressants, anti-psychotics, and stimulant medications. Over one third of the children qualified for medicare and received financial assistance.

The majority of the students lived at home with at least

one natural parent. Divorce, remarriage, and cohabitation were common living arrangements along with confusing step-family combinations. A number of students lived in group homes or foster care. Also, a significant number of adopted children were represented in this program. Most of the students were of average intelligence. Some, however, fell within the gifted range and others within the dull average range of intellectual functioning. Learning disabilities and neurological impairments were common problems.

The psychoeducational team with whom this writer worked included ten teachers certified in exceptional student education, two social workers, a part-time family therapist, a psychoeducational specialist, a full-time clinical art therapist, and part-time speech and occupational therapists. Two mornings per month, a psychiatric fellow in his or her last year of residency visited the program to provide and monitor medication for several students. The school system had a co-venture with a mental health agency that provided the social workers and psychiatric fellow for this site. The other professionals were hired directly through the school system.

This writer was the clinical art therapist for this site. She was credentialed by the American Art Therapy

Association and was also a Registered Art Therapist (A.T.R.). Working as part of a multidisciplinary team, this writer provided services to selected children in the SED program. At the time of this writing, the school system had 15 clinical art therapists servicing the psychoeducational needs of SED students in programs throughout the county. The clinical art therapist's responsibilities in the schools were to: (1) assess individual SED students' emotional and cognitive strengths and weaknesses; (2) design and implement a treatment program to both remediate the student's deficit areas and build upon existing strengths; (3) assist the team at case conferences with strategies to help the student adopt more appropriate and productive behaviors; (4) meet with parents when possible and; (5) assist and provide supportive plans in the form of educational workshops to teachers and other professionals who service special needs students. Students were assessed and reassessed at the beginning and end of each school year. Each individual and/or group session was carefully documented.

Those students who participated in art therapy were those who would most benefit from expressive therapy interventions. Art therapy is an excellent tool for individuals who have limited verbal capacities and for

those who are overly verbose and talk in order to circumvent their problems. The art therapy in this school district was used in two different ways. One is referred to as art in therapy and the other is often called art as therapy. Art in therapy is process oriented. Children confront their issues and problems in graphic formats. It is the process of creating concrete imagery that helps them secure more adaptive problem solving and decision making skills. This approach is often very directed. Students may be asked to draw specific situations and feelings. Art as therapy is more product oriented and relies heavily upon the art or graphic image. This approach is more spontaneous and facilitates creative potential and self-esteem enhancement. These two approaches can help students with the following:

(1) identify and express their feelings
(2) communicate thoughts and ideas
(3) solve personal problems
(4) make age-appropriate decisions
(5) get in touch with their environment
(6) increase reality contact
(7) learn to relate to others appropriately
(8) increase feelings of self-worth
(9) grow in self-awareness

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

Many of the elementary-aged children in this SED program had as part of their diagnosis, Attention Deficit Hyperactivity Disorder (ADHD). ADHD children often present a myriad of deviant behaviors which confounds their use of pro-social behaviors, interferes with their abilities to interact with others and form positive relationships, and inhibits their potential for social development. The ability to mainstream students into a less restrictive, more educationally balanced atmosphere is the goal of all recent educational trends. It is believed that the exceptional students who are most successful and accepted in mainstream situations are those who are able to appropriately interact with their peers and authority figures, make and maintain friendships, and respond age-appropriately in stressful situations (Fad, 1990; Whalen & Henker, 1985).

ADHD is a diagnostic syndrome characterized by poor

attention span, poor impulse control, and heightened physical mobility (hyperactivity). Presently it is the most frequently diagnosed syndrome among children and has been estimated to affect approximately 10%-20% of school age children (Shaywitz & Shaywitz, 1991).

ADHD is not a new disorder. In the past, it has been called; Brain-Injured Child (1940s), Minimal Brain Damage (1950s), Minimal Brain Dysfunction (1960s-70s), and Attention Deficit Disorder with or without Hyperactivity (1980). In 1987, ADHD was established in the Diagnostic and Statistical Manual of Mental Disorders (DSM III) as a separate diagnostic category. The different names given to this disorder suggest that there is a strong connection between organic problems and the child's deviant behaviors and maladjustment. Barkley (1990) proposed the following possible etiologies for ADHD: (1) neurological abnormalities such as neurochemical problems and immaturity; (2) genetic components such as heredity transmission or genetic abnormalities; (3) psychosocial problems such as stress, family dysfunction or poor child management; and (4) toxins/allergens such as allergic reactions to food substances or side effects of medications. While all of these are possibilities, there is presently no known cause for ADHD (Barkley, 1990;

Shaywitz & Shaywitz, 1991; Branceleone, 1988; Whalen & Henker, 1985).

Children with ADHD are highly distractible, fidgety, and rarely complete a single task. ADHD children appear to be in constant motion. They talk incessantly, can not wait their turn, and exhibit poor frustration tolerance. Following directions is extremely difficult for ADHD children (Children with Attention Deficit Disorder/ C.H.A.D.D., 1988). All of these behaviors negatively affect their ability to make and/or sustain positive peer relationships.

ADHD is an not an educational placement term but rather a diagnostic syndrome. It is interesting, however, that it is most often diagnosed either when a child enters school or shortly thereafter. The factors affecting an ADHD child's placement in an educational placement are multidimensional. It is this writer's experience that children with ADHD: (1) have problems in the cognitive, emotional, and social realms of functioning, (2) are often best serviced in a psychodeducational setting that addresses their attention difficulties, social deficits, and feelings of self-worth in conjuction with learning and, (3) are very similar in behaviors to those who have severe emotional and behavioral problems but do not carry the

label of ADHD. ADHD as one of the most common neurological disorders in children is the most frequently diagnosed syndrome among school-aged children in the U.S.A. (Barkley, 1990; Branceleone, 1988; C.H.A.D.D., 1988; Shaywitz & Shaywitz, 1991). In children with ADHD, the deviant behaviors occur in many situations such as school, home, and play. The age of onset for ADHD is before seven years of age with a mean age of four. For a child to be diagnosed with ADHD, the symptoms must be observable for over a six month period, be deviant for the child's mental age, and exclude diagnoses such as autism, psychosis and mental retardation (DSM III, 1987). As with all exceptionalities, ADHD effects the male population much more often than the female.

Although the students in the writer's setting received positive reinforcement in the classroom for their on-task and non-disruptive behaviors, those students with ADHD continued to have difficulty, especially in the realm of social interaction with their peers who were less accepting of their highly charged activity levels. All of the children in the writer's setting received a generalized, activity oriented, group therapy with the site's social workers. However, it appeared that ADHD children and those with similar dysfunctions, could not

take advantage of these group opportunities to effectively increase their social skills. With behavioral modification training in the SED classroom, the ADHD children, seemed to improve their ability to follow teacher directions (such as, raise your hand and sit down) but failed to absorb the subtleties of behaviors which generate and sustain interpersonal relationships. There was, however, no format to address the specific social development of each child to increase his or her abilitiy to: (1) "read" social cues; (2) remediate poor problem solving strategies; and (3) promote the use of pro-social behaviors and socially acceptable modes of interaction. Without intervention, ADHD children appeared to continue to be unaware of their peers feelings and were therefore isolated in play both at school and at home.

The problem as observed by this writer is that children labeled ADHD with comorbidity (ie. oppositional/ defiant disorders) have poor social development. In addition, they have limited opportunities to promote their social growth because they fail to recognize and respond appropriately to social cues that would enable them to interact with others in a positive, acceptable manner. Their social development is therefore impeded.

Problem Documentation

Evidence that children labeled ADHD with comorbidity do not use pro-social behaviors was supported by observations, psychological evaluations that suggested difficulties in the social realm of interaction, parent and teacher reports, and interviews with the students labeled as ADHD.

Many of the SED children in this program had, as part of their diagnosis, ADHD. Their psychological evaluations suggested that these children exhibited interpersonal difficulties and had deficits in the social realm of functioning. Oppositional and Conduct Disorders were two commonly found diagnoses among the children labeled ADHD in this SED program.

This writer observed children diagnosed with ADHD in this SED setting interacting with other students and instructional personnel. During activity time, the ADHD children appeared bossy, loud, and unable to let other children take turns at games. They seemed stubborn and unwilling to deviate from their initial plan. They could not accommodate another child nor could they follow through on an adult directive even when it meant that there would be a positive outcome for compliance. During physical education class, those students identified as ADHD became

physically and verbally aggressive when they didn't get their own way. They seemed unaware of the other child's need for personal space. Pushing and bumping, seemingly without any thought of how their behaviors might affect someone else, was a common sight. The children observed did not take responsibility for their own behaviors but rather blamed others for their problems. In play, the children labeled as ADHD appeared more volatile than their SED counterparts. In a short amount of time they switched from being overly silly and laughing to sulking and pouting. When given a direction by the teacher in charge, their oppositional tendencies seemed to take over making compliance very difficult. Many of their behaviors were considered as very immature. Interestingly, this writer observed that although all of the SED children in this program had problems in the realm of social development, their peer interactions were not characterised by the same degree of bossiness, rudeness, and aggressiveness as those who carried the ADHD label.

Parents of ADHD children confirmed the observed absence of pro-social development in their children. Parents reported that their child had no friends in the neighborhood and that other children did not like to play with their child. Problems with siblings were common.

Marital problems were frequently reported. Parents reported being unable to go on social outings, such as a restaurant or a family gathering, due to their child's behaviors. Many fathers reported that they didn't engage with their sons because their public behaviors were an embarrassment. These situations further isolated the child making the opportunities for social development more limited.

Teachers in the program were looking for ways to help the children labeled as ADHD focus, attend to task, and achieve academic success. Due to the high profile of stimulant medication for ADHD children, many teachers actively pursued this line of intervention through parent contact and discussions with the site's psychiatric fellow. ADHD children tended to consume a great deal of the teacher's time, to alienate themselves from others, and to promote negativity. Unable to self-regulate, ADHD children were described by their teachers as being "all over the place". Teachers reported having difficulty being positive with this type of student. Potentially, other children in the classroom can pick up the attitudes reflected by the teacher. ADHD children often become the "scapegoat" when classroom behavioral disruptions arise.

This writer interviewed the children in this setting who carried the label ADHD with comorbidity. Each child

expressed sadness over an inability to both make and sustain relationships with their peers. They did not perceive themselves as overbearing, rude, and uncooperative. Their peers' rejections greatly interfered with their positive sense of self. Poor self-esteem was commonly found among ADHD children, especially those who had oppositional tendencies.

Causative Analysis

The possible causes for under-socialized development in children with an ADHD component to their diagnosis are varied. Researchers have asked whether or not the child in question has difficulties: (1) perceiving social situations; (2) generating appropriate problem solving solutions or; (3) applying problem solving strategies (Hughes & Hall, 1987). It is possible that ADHD children have difficulties in all three realms of social competency. They may not only lack social skills but lack the motivation to use those that they do have.

A strong indicator of ADHD is impulsive behavior. Acting impulsively, children with ADHD do not take the time to reflect on a situation and react in haste, guided by only their instincts (Barkley, 1990; Shaywitz & Shaywitz,

1991; Whalen & Henker, 1985)

Other children do not want to play with aggressive, bossy, and uncooperative children. Since ADHD children are often excluded from play activities with their peers, they have limited opportunity to learn socially adaptive behaviors. This type of interaction becomes cyclical in nature. Most children won't play with or avoid children with ADHD. ADHD children in turn become more angry, isolated, and unused to sharing and cooperating. ADHD children are more immature than their peers and therefore have difficulty relating to others in an age-appropriate manner. Their mood swings confuse and frighten other children. Their inability to stay with one game or a single activity for a prolonged period of time promotes rejection of them as potential playmates (Carlson, Lahey, Frame, & Walker, 1987).

ADHD children are often unpopular at school. Because of their disruptive classroom behaviors, teachers do not choose ADHD children to participate in a an activity or call upon them to answer posed questions. Even in an SED setting this writer observed that these children stand out as more disruptive than the others. ADHD children seldom get the positive feedback afforded their peers. ADHD children with concommitant problems often feel that no one

likes them and discontinue pursuing social activities that bolster feelings of self-worth.

Many ADHD children are isolated at home. Although hyperactivity is a hallmark of their dysfunction, they are able to spend hours watching television thoroughly absorbed in non-interactive pursuits of entertainment. This reclusive lifestyle is contrary to the developmental needs of the school-aged child wherein social development is a primary function (Carlson, et. al., 1987).

Relationship of the Problem to the Literature

The review of the literature suggested that children identified as ADHD have a myriad of behaviors that interferes with normal social development.

The preliminary review of the literature indicated that children with ADHD have many behaviors that negatively affects both their acquisition and use of pro-social behaviors. According to Barkley (1990), Shaywitz and Shaywitz (1991), and Kolko (1990), ADHD children often exhibit verbal and physical aggression, destructiveness, and temper tantrums or angry outbursts at seemingly insignificant events. They are often academic underachievers, learning disabled or of low average

intelligence. In addition, ADHD children stand out due to their tendency to over-react to situations. They have a low frustration tolerance, poor self-esteem, and are very impulsive. They have difficulty focusing and move from activity to activity with seemingly little forethought. In their research, the authors also found that ADHD children appeared unable to reflect or empathize with their peers. Their social skills were very limited. Research indicated that there was increased incidences of police involvement, anti-social acts, delinquency, and a greater suicide rate among those adults and adolescents who had been labeled ADHD as children. With this profile, it is not surprising that students with AHDH are "at risk" for school drop-out and are poor employment risks.

The literature also suggested that ADHD children seemed unable to judge social situations. They found transition from one activity to the next, difficult. Children with ADHD lacked friends. Studies have shown that they were generally unliked by their peers (Pelham & Milich, 1984).

The literature gave other evidence to problems ADHD children have with incorporating pro-social behaviors into their repertoire of behaviors. Research suggested that children with ADHD were not only impulsive but exhibited emotional immaturity, self-centeredness, and social

ineptitude (Branceleone, 1988; Kolko, Loar & Sturnick, 1990). Behaviors that one would find acceptable in a two year old child are not acceptable in a ten year old. ADHD children seem to use the same problem solving behaviors that they had used as small children. They whine, sulk, and pout or become bossy and aggressive when they don't get their way. They tend to run around haphazardly, not paying attention to others (Newby, Fischer, & Roman, 1991).

ADHD was often first recognized when a child entered school. This is because they can neither sit to listen to the teacher read a book nor finish their own school work. They are unable to comply with the demands of a school structure and are therefore unable to win the teacher's approval. The behaviors of ADHD children makes them unpopular with their teachers which adds to their low self-esteem and feelings of social incompetency.

In support of what this writer observed in her program, the literature suggested that the majority of ADHD children have comorbid features with their initial diagnosis (Barkley, 1990; Shaywitz & Shaywitz, 1991). Although some school-aged children with ADHD are either in regular education settings or Learning Disabilities classrooms, others are frequently found in classes for the

Emotionally Handicapped. All of the ADHD children at the SED program where this writer worked had a dual diagnosis. ADHD was only a component of their dysfunction. Conditions most often found in conjunction with with ADHD were; oppositional/conduct disorder, academic performance problems, and emotional immaturity. Oppositional disorders in children are marked by high degrees of defiance. ADHD children tend to use oppositional behaviors to get their way regardless of the outcomes. The opposition may be of a passive or aggressive nature. For example, in order to get his or her own way, a child may selectively tune-out a given direction. This writer observed a six year old boy stubbornly refuse to put a paper bag in the place where he had found it even though there were unpleasant consequences for not following teacher directions. The willfulness so often observed in ADHD children is common for a two year old child and supported the research on extreme emotional immaturity in ADHD children (Branceleone, 1988).

The literature suggested several possible causes for underdeveloped socialization and the absence of pro-social behaviors among children with ADHD. Although many children with handicapping conditions have problems in the social arena, none were so severe as those who were either emotionally disturbed or those who were labeled as ADHD

(Carlson, et. al., 1987; Landau & Milich, 1988).

Although most of the literature stressed a cognitive processing problem when discussing social skills deficits in ADHD children, other researchers felt that there may be additional reasons for underdeveloped socialization in that population. Landau and Milich (1988) felt that mother-infant attachment was significantly correlated with the adequacy of peer relationships. Since securely attached infants exhibit less aggressiveness and better social adaptation, the authors contend that socially inept children had problems "bonding" during infancy. Parenting styles also contribute to behavioral problems which impact upon peer relationships. They believed that the hyperactive child is caught up in a negative, reciprocal interaction between himself and the parent. Non-compliance is a feature of ADHD that creates escalating patterns of aversive behavior and negative parent-child interactions (Newby, Fisher, & Roman, 1991). Unfortunately, this interaction is replayed in the classroom by the teacher whose response to hyperactive children may be harsh and punitive.

ADHD children may not be sensitive to changing situational demands (Landau & Milich, 1988; Wells, 1986). In studies wherein children needed to change and shift

their roles or modes of interaction in order to successfully interact with others, ADHD children consistently failed to modulate their behaviors. They did not respond to social cues and remained inappropriately consistent in their behaviors. Their social rigidity makes them at risk for disturbed peer relationships and rejection.

This writer's observations of ADHD children supported this finding. When ADHD children were observed playing with a particular toy or game, they consistently exhibited an inability to stop playing upon peer or adult request. Another example was noted by this writer during art therapy sessions with a student whose partial diagnosis was ADHD. At the close of each session, this student was unable to desist with the activity. Both his classroom teacher and mother reported that same behavior. Although this behavior is often a function of an oppositional disorder, it may also be akin to a rigidity of thought or an over-focusing that does not allow for a flexibility of action. As a result, these children often appear self-centered or self-absorbed. The self-centeredness of ADHD children makes them unable to take another's position and develop age appropriate empathy. Therefore, they do not seem to realize and/or comprehend the feelings of others

and are automatically set up for rejection.

Underdeveloped social skills in ADHD children may also be a result of their lack of experience with positive peer interactions. ADHD children are generally unliked. They are frequently in trouble at school, aggressive, and exhibit poor academics (Hinshaw, Henker, Whalen & Erhardt, 1989). Contributing to their unpopularity is their tendency to become easily frustrated. Due to their non-conforming behaviors, ADHD children are rarely chosen as playmates by their peers (Ullman & Sleator, 1985). In addition, their high degrees of physical mobility, inattentiveness, incessant talking, and tendency to interrupt, interfere with the possibility for reflective thought.

The various topical areas researched were: Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, Social Skills Training in Children, Hyperactivity in School-Aged Children, School-Aged children and Pro-social Behaviors, Social Development and Emotionally Disturbed Children, and Socialization and Special Education.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The goal of this practicum was to increase the social competency of the students participating in this writer's program by improving their ability to accurately identify social cues, generate problem solving strategies in social situations, and apply these skills in a supervised setting.

At the conclusion of this practicum experience, it was expected that students' feelings of self-worth and use of pro-social behaviors would improve. In addition, it was expected that the children would be able to interact with their peers in a more socially acceptable manner in a supervised setting. Their ability to reflect upon their own feelings and the feelings of others would also be improved. It was additionally expected that the children in the program would improve their ability to understand cause and effect relationships that pertain to social interactions.

Expected Outcomes

The following outcomes were projected for this practicum. The children participating in this writer's program would be able to identify one or more persons with whom they are on friendly terms, describe what a friend is, and what specific behaviors exhibit friendship. Their ability to "read" social situations would be improved. They would have ideas for solving social problems and name specific incidences where they felt successful at solving a social problem. Reports of fighting incidences were expected to decrease. The number of observable, co-operative sharing, and taking turns behaviors were expected to increase.

Measurement of Outcomes

Each child participating in the program had a progress folder. This writer determined the progress of social growth and improved socialization of the children in her program in three ways. One measure was the number of reports made by the student's teacher and group leader about his or her social behaviors in the classroom, in group therapy activities, and on the bus. To insure consistent reporting, the teachers involved were first made

aware of which students were participating in this writer's program and second, were contacted one time per week for a verbal report on the student's social progress. Specific areas, such as the number of fighting and arguing incidences in both structured and non-structured social situations were discussed.

The second measure consisted of observations made by this writer during structured classroom activities and unstructured play in the after-school program. The general observations included positive, self-statements made by the students, an improved frustration tolerance as seen in a decreased destruction of school or play materials, an increased time on task, the appearance of a calm or appropriate affect, an improved ability to control actions and words, and a decrease in both verbal and physical aggression.

The third measure combined graphic reproductions and verbal associations of the students during art therapy sessions. The graphic reproductions included two and three dimensional art works. To assess improvement, the writer first looked for an increase in the use of pro-social thoughts and ideas depicted by the students in their graphic responses. Directed themes such as; draw the meaning of friendship, draw activities to do with a friend,

and draw a picture of a problem you had with a friend and how you solved it, provided ample material from which this writer could assess a student's progress. The solutions to directed themes required reflective and empathetic thought and age-appropriate decision making skills. The writer stressed the use of sequential story lines and asked the student to put reality oriented conclusions to their graphic scenarios.

In addition, the student's spontaneous art works during sessions were assessed in terms of increased self-control while maintaining the ability to express issues and concerns. Graphic depictions together with verbal associations became visual records. They provided a format to assess social growth and potential improvement. They supplied immediate feedback and visible means to promote discussion. The students' abilities for appropriate peer interaction were measured by graphic reproductions portraying accurate perceptions of cause and effect relationships and accurate, reality based, verbal comments that conveyed increased self-control and coping mechanisms.

Another type of assessment consisted of using modifications of a social deficit questionnaire proposed by Hughes and Hall (1987). This writer created several social dilemma drawings and asked the students to: (1) "read" the

picture and tell what is happening; (2) draw a solution to the social problem presented; and (3) state if you would solve the problem in a similar way. These drawings were administered in a pre and post format and measured in terms of increased accuracy at reading the social dilemma drawings and generating and applying socially acceptable solutions to the problem (appendix B).

Mechanism for Recording Unexpected Events

Unexpected events were recorded by this writer in a journal. The journal recorded what transpired at each session with the children in the program, the reports from the student's social worker, and comments made by the student's classroom teacher. This journal had a section for parent contact in the event that parent contact was made.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

Children with Attention Deficit Hyperactivity Disorder (ADHD) have poor social development. They have limited opportunity to promote their social growth because they continually use socially unacceptable behaviors. Children with ADHD fail to recognize and respond to social cues that would help them interact with others in a positive manner. In this writer's work setting there are many students who have, as part of their diagnosis, ADHD. The literature suggested that it is in the social realm that a student either "makes or breaks" a mainstreamed situation (Barkley, 1990; Fad, 1987). Therefore, it is important for these students to receive a specialized program that fosters social development.

What is the best overall plan or treatment for children with ADHD? Currently, ADHD is a pressing topic. There are many teacher training classes and workshops in behavior modification, parent support groups, group therapy, and

specialized training programs for ADHD children. There has been research into medication and therapeutic interventions for ADHD children. At this time, parents, teachers, and mental health practitioners do not always agree on a plan of action for the child. There are too many medication, program, and legislative issues.

The literature suggested several solutions. Stimulant medication (Methylphenidate) has been well documented as the treatment of choice for children with ADHD (Hinshaw, Whalen & Erhardt, 1989). Stimulant medication has positive effects on children with attention difficulties. It helps them focus, attend, and become less impulsive. Potential negative side effects in some children include tic-like symptoms, a decreased appetite, and a delayed physical growth.

Cognitive training or cognitive therapy in conjunction with medication has been suggested as a way to remediate social skill deficits (Ullman & Sleator, 1985). In their study, Ullman and Sleator found that although medication had a profound effect on the children's attending behaviors, it had little positive effect upon their social interactions. They concluded, that cognitive therapy and social skills training may be needed in conjunction with medication.

In their study with behaviorally disordered children, Yu, Harris, Solovitz, and Franklin (1986) found that the children responded well to interventions which had a strong social problem solving component to their modality. Landau and Moore (1991) advocated the use of psychostimulant medication and problem solving/anger control strategies in a therapeutic mileu to remediate the social problems of ADHD children. Cognitive therapy can be conceptualized as a facilitator for age-appropriate problem solving, decision making and judgment skill use. Problem solving strategies, when specific in nature, help ADHD children cope successfully and find alternative ways to control their anger and other acting out behaviors (Hinshaw, Henker, & Whalen, 1984).

Behavioral training and Cognitive Behavioral Self-Control Therapy has also received some success at improving the non-compliant behaviors of ADHD children. According to the research of Horn, Ialongo, Popovich and Peradotto (1987), children who were taught to perceive themselves as responsible for their own behaviors, adopted more pro-social behaviors. Behavior modification programs are often used with ADHD children. However, most advocates of behavior therapy contend that it must be combined with psychostimulant medication to be effective (Wells, 1986).

For the purposes of investigating solutions to the problem of underdeveloped socialization in ADHD children, this writer reviewed some recent studies in order to ascertain which methods of treatment and intervention have been used with ADHD with the greatest success. All of the studies reviewed were experimental research and all but four had control groups. Improvement was considered positive if behavioral changes were observed in the experimental group. These changes included increased frustration tolerance, improved time on task and attentiveness, an improvement in social interactions, decreased aggressiveness, a decline in verbal interruptions, and decreased overbearing or bossy behaviors when interacting with peers. While some researchers discussed the ability to transfer behavioral gains to more natural settings, this review did not take into account whether or not the subject was able to generalize improved, more socially acceptable behaviors. Only behavioral changes in the test setting were considered.

On the following pages, two charts are presented that delineate much of the findings from the research. The characteristics of the studies reviewed are presented in Table 1. The table includes (a) the names of the

researchers; (b) the publication date of the research; (c) the number, (d) sex, (e) diagnosis and (f) age of the experimental and control subjects; (g) the basic approach used with the experimental group, e.g., individual intervention, group intervention, dyad, mixed dyad; (h) the type of intervention employed, e.g., medication, behavioral therapy, social skills training, cognitive training, role playing, and reinforcement either tangible or verbal praise; (i) behaviors remediated; and (j) results that reflected either a status quo, or improved behaviors. Table II is a condensed summary of the findings.

Table 1
Interventions with Children Diagnosed as ADD or ADHD

AUTHOR	SEX	SUBJECT# E	SUBJECT# C	APPROACH	TYPE	B.REM.	RESULTS
Hinshaw (1989)	M	25	15	I	M	AOE	+
Horn (1987)	M/F	24	0	I/G	SST, CT,BT	O	0
Kolko (1990)	M	36	20	G	RP/GT	NBS	+
Landau (1988)	M	17	18	MD	RP	O	0
Ullman (1985)	M/F	86	0	G	M	OEBN	+
Van Hasselt (1984)	M	1	0	I	SST BT	AOE	+
Wells (1986)	M	8	0	I	M/ PT/ BT	AOEBNS O	+ 0
Yu (1986)	M	23	0	G	SST	AOEBNS	+
Zayas (1986)	M	8	0	G	RP	AOE	+

ALL CHILDREN WERE BETWEEN AGES 6-12

ALL CHILDREN WERE ADHD/ADD--SOME WITH COMORBID FEATURES
(Learning disabilities and Behavioral Disorders)
SUBJECT #: E= Experimental: C=Control

SEX: M= male: F= female: M/F= male and female

APPROACH=APPROACH TO INTERVENTION
I=Indivdual; G=Group; D=Dyad; MD=Mixed Dyad(e.g. one ADD)

TYPE=TYPE OF INTERVENTION USED: B.REM.=BEHAVIOR REMEDIATED

M= Medication	A=aggressive
RP= Role Playing	O= Off task
PT= Parent Training	B= bossiness
CT= Cognitive Training	E= excessive activity
SST= Social Skills Training	N= regard for others
BT= Behavioral Training	S= social interactions
VPR=Verbal Positive Reinforcement	
TPR= Tangible Positive Reinforcement	

RESULTS: + = positive; 0 = no change

Below, Table 2 provides a simple summary of the type of intervention employed and the results in terms of no observed behavioral changes (No Changes) and improved behavioral changes (Positive Changes).

Table 2

Summary of the Interventions from Table 1

Author/Date	Type of Intervention	Results
Hinshaw/1989	Medication	Positive Changes*
Horn/1987	Social Skills Training	No Changes
	Cognitive/Behavioral	No Changes
Kolko/1990	Role Playing and Group therapy	Positive Changes
Landau/1988	Role Playing	No Changes
Ullman/1985	Medication	Positive Changes*
Van Hasselt/1984	Social Skills Training Behavioral Therapy	Positive Changes
Wells/1986	Medication, Behavioral and Parent Training	Positive Changes*
	Behavioral Therapy alone	No Changes
	Parent Training alone	No Changes
Yu/1986	Social Skills Training	Positive Changes
Zayas/1986	Role Playing	Positive Changes

* = studies that used medication in treatment

The interventions used with ADHD children in the studies in Tables 1 and 2 ranged from medication only, to therapy only, and to a combination of therapy and medication. Looking at tables, the reader can see that the studies that employed medication (Methylphenidate) only and medication plus therapy, all reported positive changes in their experimental group of ADHD children. The studies that treated ADHD children with cognitive therapy, social skills training, and therapeutic interventions (such as behavior therapy and role playing) had mixed results. Some of the studies that used training or therapy without medication, documented positive changes through observations and self-reports. Others, who had used therapy or training without medication, stated that they could ascertain no improvement in the behaviors of these children. Across the board, whether the research involved medication or therapy, few improvements were appreciably found in the areas of social interactions. Parent training, although strongly advocated by Barkley (1990) and C.H.A.D.D., (1988), did not have a measurable effect on children who were not medication involved (Wells, 1986).

This writer felt that some of the more favorable results found in the research that employed only therapeutic intervention without medication with ADHD

children may be a function of: (1) the duration of the therapy; some of the pre and post assessments of behavioral change were taken immediately after the therapeutic intervention, and (2) the type (e.g. role playing versus social skills training); role playing, as it is more kinesthetically involved, may heighten the arousal level and achieve a focusing effect with ADHD children. Social skills training, relying on the cognitive domain, may be less effective as it relies on verbal skills. Many ADHD children, similar to learning disabled children, have a weakness in the verbal domain.

However, looking at the tables, it seems clear that medication consistently achieved positive results in the facilitation of positive behavioral changes among ADHD children whereas therapy only was sometimes helpful at best. Popular pharmacological treatments included stimulant medications such as Ritalin, Dexedrine, and Cylert. When children diagnosed as ADHD were taking medication, research stated that there was an observed increase in attention span and compliance, a decrease in impulsivity and aggressiveness, and an improvement in handwriting and fine motor skills. However, there were potential side effects to stimulant drugs. Some of them included insomnia and a decreased appetite, depression, headaches, stomach aches,

and motoric tics (Barkley, 1990).

Other ideas to address the need for improved social competency among those children labeled, ADHD were generated. Research suggested that due to the high incidence of comorbidity among ADHD children, treatment may need to be individually designed. Therefore, one idea generated was that children labeled as ADHD and SED would benefit from a specific intervention program either individually or in a dyad format. The program needed to be designed in such a way as to support the emotional and social development of these children while supplying them the opportunity to use less traditional, more non-verbal means to focus on the meaning of friendship and understand their role in relation to other children and adults. The realm of expressive therapies offered this opportunity.

Another idea was increased parent contact to both offer the parent support and let the child know that the school and home are working together as one unit. This could be accomplished through the site's social workers whose job it was to keep parent contact. Parents and students needed more information about medication. This writer observed that children taking stimulant medication are smaller in stature and thinner than their peers. At around ages 10-11, this becomes an issue for boys who are becoming more

atuned to their physique. In addition, this writer spoke to parents who were extremely fearful of any type of medication. They felt that the school was using medication to avoid dealing with their child. Some parents had themselves been alcohol and/or drug involved and feared the repercussions of dependency upon a drug to regulate behaviors. Since consistent behavioral improvements have been substantiated using medication, parents needed additional counseling and training to address the issues surrounding the use of medication.

Contact meetings with both the student's teacher and social worker were helpful to identify specific areas of social problems, to discuss possible modes of intervention in a variety of settings, and to assess results of interventions used.

Description of Selected Solution

From the research, it appeared that children who were diagnosed with ADHD needed help not only in the behavioral and academic realms of functioning, but in the emotional and social realms as well.

Therefore, the following procedures were attempted to improve the social growth of children in the writer's psychoeducational program. A selected group of elementary-

aged children with ADHD as a component to their diagnosis were chosen to participate in a special program wherein expressive therapy was used to facilitate pro-social behaviors and social development. The necessary permission was obtained to implement the program.

The children chosen to participate in the program had a diagnosis of ADHD with comorbid oppositional/conduct disorders or were SED children whose behaviors were very similar to those delineated in the DSM III for ADHD. The students were serviced in either a dyad or individually depending upon their specific needs. The children met with the writer, one time per week for a 30 to 45 minute session. They were also observed in both structured and non-structured settings in the classroom or in an after-school care program on a weekly basis.

In addition, this writer met with the psychiatric fellow at the SED site to discuss the ADHD students on his case load. Since the research into interventions that improved the attending and focusing behaviors of ADHD children suggested that medication (stimulants) were necessary components for positive behavioral changes, a medical component is advocated by this writer as a need for ADHD children who have comorbid features to their diagnosis. Due to their rapid growth, medication

monitoring by a physician should be monthly. The student's teacher and social worker should also be atuned to the child's medications. The ideas generated and relayed in the above section were incorporated into the plan.

The plan to improve the social competency of ADHD children in the SED program worked for several reasons. It was this writer's belief that improvement in the realms of self-esteem and positive peer interactions could be achieved with the help of medication and through a social growth program that employed art therapy techniques. Since the emotional development of the ADHD child is immature, this writer's program promoted social development through the acquisition of age-appropriate social skills. It dealt with the student's feelings self-worth, social competency, and acceptable expressions of anger and frustration. The research suggested that role playing, an action oriented therapy, seemed to have positive results. Therefore, ADHD children had a good chance of benefitting from other kinesthetic interventions such as, movement, music, and art therapy. This writer was a registered, clinical art therapist and was credentialed with the American Art Therapy Association. She had a great deal of experience with impulsive and hyperactive children and had done extensive research into children's social development.

This plan was successful as the students' classroom teachers and social worker appreciated receiving help and were open to ideas from this writer. In addition, the students expressed a desire to learn how to make and sustain friendships.

This writer took the following steps prior to implementing this program. She obtained; (1) permission from her supervisor to undertake such a project, (2) permission from the student's parent or guardian, and (3) permission to speak with the student's private physician or psychiatrist. This was helpful for those students not being serviced by the site's psychiatric fellow. This writer then assessed the social needs of each student through a series of interviews with the student and his or her parents and/or teachers. The writer familiarized herself with the student's psychosocial history, previous school functioning, and home interactions.

This writer structured the basic activities during the student's sessions to promote pro-social behaviors. The structure included a focus upon problem solving in specific situations and taught strategies for controlling anger and finding alternative, socially acceptable ways of expressing negative feelings. The students practiced positive modes of interaction in contrived, social

situations through role playing, drawing, and play. They used art media to facilitate problem solving, personal expression, and age-appropriate social decisions. The students were taught a relaxation technique as a way to curtail impulsivity and promote reflective thought.

Report of Action Taken

A projected time line for this project was eight months. The same students were in the program for a four month term. Many students, however, worked on social competency along with other issues for the entire eight month period. During this time period careful records were kept. Contact was kept with the student's teacher, social worker, and parent (by self or social worker).

During the first month of the practicum each student was seen one time per week in an individual session and observed one time per week in the classroom. The students were interviewed and assessed for social competency using a modified Hughes and Hall (1990) model to ascertain whether they had problems identifying social cues, generating solutions to social dilemmas, or appling appropriate solutions. The modification included having the students look at a "social dilemma" picture drawn by this writer and answering what they thought was happening (appendix C). The

students were then asked to draw a solution to social problem and asked if they would solve it in a similar manner.

The child's teachers, social worker, and parents (when possible) were contacted. Scheduled meetings were set.

Since research indicates that individual programs worked best with ADHD due to the complexity of their disorder (Whalen & Henker, 1985; Landau & Moore, 1991) time was spent this first month evaluating each child through several means to determine what area of social interaction was in greatest need of remediation (ie. anger control, frustration tolerance, or skill training). It was determined which students could be grouped successfully and which required individual services.

The focus of the second month and the first half of the third month was facilitating appropriate peer interactions. Both structured and semi-structured formats were employed to allow for increasing social awareness.

In a more structured format, children were given simulated (visual) social situation problems and read short vignettes containing social problems (Forte, 1983). In response to the presented situations, the children drew possible solutions. The discussions that followed revolved around making good choices and increasing their empathetic

responsiveness. This directed format allowed for ongoing assessment as the children's social growth improved.

Drawing helps make events more concrete, circumvents possible verbal manipulations, and assists with direct focusing and increased reality contact. It does not rely on verbal forms of communication and therefore does not confound the child who perhaps has auditory processing problems and/or deficits in the verbal domains of functioning. Rather, it is more kinesthetic in nature and helps the hyperactive child channel physical mobility and rapid thoughts constructively and sometimes, even productively.

During this time period, the children were also asked to fold their paper in half and on one side draw a true recent peer interaction wherein a disagreement ensued. On the other half the child was asked to draw, (1) what actually transpired and (2) two alternatives to what had transpired. Discussions included the use of pro-social interactions.

A less structured format was then employed. The students were asked to draw four things that they enjoyed doing with friends. This helped them view themselves as interacting positively with peers. The follow-up to this was having students make up a story for each of their four

drawings. The story could be real or fictional but needed to be logical and sequential and involve at least; (1) two people engaged in the portrayed activity; (2) a problem that occurs disrupting the activity; and (3) a positive solution to end the story.

Another open-ended directive was given to the students. Students were asked to draw a friendship picture and tell what friendship meant to them, what was a friend or how they show they were a friend to someone. Teacher, social worker, and family contact was maintained when possible.

Role playing was used as a perspective taking mode and a step towards developing empathy during the later part of the third month. In pretend play, each student assumed the identity of different people with whom they interacted on a daily basis. Examples included; a teacher, a parent, a person they wished were their friend, an enemy, or a neighbor or classmate with whom they had difficulties. The students acted out in play, "If I Were You", and told how they felt, what they would say, what they would do, and how they would act if they were that person. Some children created visual props to help them assume the character of the person they pretended to be. Paper masks were very popular for this activity. Hands-on, creative activities

helped them focus and attend. Weekly teacher and social worker contact was maintained.

Midway through the practicum, gaining control of self (behaviors and feelings) took precident. Each student found an appropriate coping strategy to employ when he or she felt about to be overcome by feelings of anger or frustration. Students were taught to first recognize their internal (body) feelings prior to acting on their feelings and then use their coping strategy to control that feeling and finally express it in a socially acceptable manner. Students were monitored on a weekly basis. During these weeks students were exposed to a variety of two and three dimensional art materials and created expressive works of their own choosing. Discussions included how the students felt about their own ability to handle frustration, time on task, impulsive tendencies, and feelings of social competency. They were asked to name specific improvements. They were also asked if they were now better able to recognize some social cues and find socially appropriate solutions to peer problems. Naming specific incidences where improvements were perceived was important. For example, this writer would generate discussion by saying, tell me a time when...(you were successful at solving a problem with a friend, parent or teacher).

Being a friend was the theme for the culmination of the program. Students incorporated their new problem solving skills with their perspective taking and coping strategies and worked together in small groups of two or three to create a single graphic production to be displayed. The themes were of friendship, cooperation, sharing, and working together.

At the culmination of the program, each student's folder was reviewed for improved social competency and assessed through observations, graphically portrayed pro-social choices and visual depictions, verbal discussions, teacher and social worker reports, parent reports, and self-evaluations. The plan was repeated for another four months with some different dually diagnosed, ADHD students. Most students remained in the program for eight months and took advantage of the continued strategies geared towards improving social competency. This allowed for more in-depth remediation and a continual review of concepts and ideas presented earlier. Some children who had multiple emotional and social needs benefited from the continued support offered through this practicum. The students who remained in the program for the entire eight months continued to use art therapy to express their feelings, improve their social competency, increase their self-

esteem, and develop age-appropriate strategies to solve social dilemas.

CHAPTER V

RESULTS, DISCUSSION, AND RECOMMENDATIONS

Results

This writer was a clinical art therapist in a program for SED, elementary-aged children. Some of the students in the SED program were diagnosed as ADHD with comorbid features (opposition and defiance). The social development of the children with ADHD was immature. These children appeared to have limited opportunities to promote social growth at school or at home because they were often rejected by their peers, demanding and non-compliant with adults, and did not function age-appropriately in the classroom.

To improve the social competency and feelings of self-worth of children diagnosed as ADHD and SED, this writer created a therapeutic, social competency remediation program using expressive therapy as a mode of intervention. The intervention focused upon increasing the students' ability to recognize social cues, to generate problem solving strategies in social situations, and to apply learned, pro-social behaviors in supervised and/or

simulated settings. Improving anger control and frustration tolerance was included in the remediation. This writer, in the capacity of a clinical art therapist, met one time per week with students for approximately 30-45 minute sessions. Depending upon their needs, students were seen individually or serviced in a dyad format. A total of 10 students participated in the program. The sessions incorporated art therapy with verbal associations and included role playing with opportunities to apply learned, pro-social behaviors in an after-school setting. This program may be beneficial for any child experiencing poor social interactions. Although designed for those children in the writer's program who were ADHD, this writer found that the activities and exercises also benefited students labeled, SED but not ADHD. Therefore, some children who were not ADHD were also included into social competency improvement program.

Observations in structured and unstructured settings, projective drawings, and interviews with the students and their teachers were used to assess improvements in students' social competency.

At the conclusion of this practicum, all of the children had improved to some degree. It should be remembered that the children in the program were severely

impaired emotionally. Often, their home lives were in a state of continual flux and turmoil. In addition, at the onset of this practicum, many of the students were not taking medication. At the conclusion of this practicum, 7 of the 10 children were on psychotropic medications to help with attention, depression, and anxiety.

Home situations and the administration of psychotropic medications were factors that contributed to a range of observable improvements for individual children. For example, two students were initially so disruptive that they could not participate in group therapy sessions in school. Their desk in the classroom, even within a special education setting of 10-12 children, was located away from their peers. Improvements for them included the number of times they were admitted into group therapy sessions and then, were able to remain in a group session for an entire period. Another measure of improvement for them was gathered by counting the number of times they were included into the classroom structure. By this practicum's conclusion, one of the two children was able to participate in group therapy at least three out of four times and was part of the classroom structure 90% of the time. The other child's medication was never stabilized. Although he craved adult and peer attention, it was not possible to

include him into the group or classroom structure due to his impulsivity and aggressiveness. A one-to-one aide has been recommended for this student. For other students, whose behaviors were less severe, improvements were more visible. At the onset of this practicum, for example, the students spent their day in self-contained classrooms. By the practicum's conclusion, these students were able to partake in regular education classes and activities. Two of the children in the writer's social skills improvement program were mainstreamed to a regular education math class each day and one of them was included in a regular physical education class three times per week.

It was expected that each student would exhibit improved feelings of self-worth based upon feelings of competency in social situations. They should be able to more accurately interpret social cues, generate appropriate solutions to given problems, and apply pro-social behaviors in structured social settings more frequently.

Each student was administered a pre and post social dilemma drawing test created by this writer (appendix B). The students looked at the presented drawings and told what they thought was happening. They then drew a picture showing how to solve the situation. The drawings were used to measure a student's ability to "read" social situations

and to solve the problem through the use of pro-social behaviors. All of the children showed a degree of improvement in this area. Of the children labeled SED and ADHD, 9 out of 10 children showed an ability to interpret social situations correctly from the graphically presented social dilemmas. Out of that same group, six showed an improved ability to generate at least one positive solution to a given social problem presented graphically. It appeared that it was easier to understand and/or interpret what was happening than to employ pro-social behaviors to resolve uncomfortable social situations.

Students drew friendship drawings and told what it meant to be a friend (appendix C). In general, all the students' themes improved as they graphically displayed increased pro-social activities. There was less anxiety attached to this theme at the conclusion of this practicum as observed by a decrease in regression (ie. scribbling and destroying). Nine out of the ten children made friendship drawings that were appropriate for display within the school during Exceptional Student Education Week. Pride in achievement was observed in the positive expressions on the faces of the students who had their work on display.

Through interviews with the students and group leaders

it was discovered that the students' willingness to discuss solutions to social problems increased. An observable resistance to talk about individual social problems decreased for those students in this writer's program. The case manager for these students reported that progress during group therapy sessions was observable in decreased belligerence and increased rational discussions about peer problems. Teachers of these students were able to point out several situations wherein students remained calm when being reprimanded for inappropriate behavior. Physical and verbal aggression had decreased for some of the students participating in the writer's program. This writer observed several occasions in an after-school play period when a verbal reminder was all that was needed to head off potentially explosive behaviors.

The students' ability to understand cause and effect relationships improved. At the onset of this practicum the students did not seem to understand how their behaviors affected one another and resulted in either positive or negative consequences. Often the students would say that the teacher or a student acted a particular way because he or she didn't like them. There appeared to be little self-awareness and even less awareness of the world around them. Each of the students improved to some degree in this area.

Through expressive exercises and verbal discourse they displayed an improved understanding of how their attitudes and behaviors contributed to outcomes. Rather than arguing and blaming someone else for their predicament, students were more able to honestly approach their problems and show ownership for their behaviors (appendix C). It should be remembered, however, that each student needed a verbal cue to respond in such a manner. Spontaneous ownership of problems was not observed during this practicum. With practice the number of necessary prompts or social behavior cues decreased for 4 out of the 10 students. Practice included having the students graphically relay a particular peer problem they encountered that week, describe their involvement in the situation, and discuss the outcome.

As the social skills training during the practicum progressed, students were more frequently able to use "I" statements and understand their own contributions to ensuing peer problems. This activity appeared to diffuse angry outbursts and give students an opportunity to view what had happened from their own perspective. The process of portraying problem events graphically had many positive results. It made concrete those feelings and issues that tended to get exaggerated through speech. Events became

more real and connected to people and the environment. It enabled the students to distance themselves from the event long enough to look at it critically, talk about it rationally, and take another's perspective.

During individual and/or dyad art therapy sessions students became increasingly aware of how their behaviors impacted upon their lives. They did not always agree with what transpired (at home or in the classroom) but they began to understand how unbridled anger and low frustration brought negative results. This writer found that an excellent drawing exercise for increasing students' awareness of cause and effect relationships was the activity, "My Problem and How I Solved It" (appendix C). The visual image clarified nebulous situations and helped ADHD children focus on events, feelings, and results.

This writer also anticipated that during art therapy sessions, students would exhibit a decrease in destruction towards their art works, an increased time on art task, an improvement in appropriate or calm affect, and increased positive, self-statements. Each student improved in these areas. They all had an increased number of intact art works as represented in their art folders and fewer requests to begin a given task over again. As the

practicum progressed, positive self-statements increased. The students were able to compliment themselves for a job well done and showed pride in their achievements through positive body language. Seven of the ten students improved in the area of "time on task" or decreased impulsivity. Although the process of making art did help them focus, initially these children still had a tendency to jump from topic to topic and media to media. List making helped curb impulsive tendencies and by the end of the practicum, three of the students were creating self-initiated lists to help them organize their thoughts and ideas.

Areas that showed little or no improvement revolved around the students' abilities to transfer and apply pro-social behaviors and positive, social problem solving solutions to home and/or non-structured environments. Although behaviors at school noticeably improved, some parents continued to report problems with disciplining their children and fighting with siblings.

The improvements noted during this practicum period can not be attributed solely to the social competency program. Maturation, medication, teacher influence, a structured class and play environment, and individual and group therapy, all played a vital role in helping the students feel more competent and able to solve social dilemmas.

To give the reader a better understanding of the SED and ADHD population and the positive results from the use of expressive techniques in therapy to improve social competency, this writer has included sample highlights from two cases in her program. To insure confidentiality the names and ages of the children have been changed.

Case Highlights of Gilberto

Gilberto, a nine year old boy, had been participating in art therapy sessions with the writer for over a year prior to his enrollment in the social competency program. Although a working relationship had finally been established, little overall progress had made. He still jumped from topic to topic and moved from art media to art media. He was oppositional, controlling, and would out talk or out yell anyone who confronted or challenged him. Rigidity and resistance were well established as a repertoire of behaviors for Gilberto. He was impulsive and displayed much of the anxiety associated with depressed children. Part of his diagnosis was ADHD. Severe learning disabilities contributed to his poor academics and low self-worth.

The themes of Gilberto's art products reflected the degree of immaturity found in the research about ADHD

children. His grapho-motor skills were age-appropriate but he chose to make stuffed animals and mobiles with teddy bear characters. His peer interactions were poor, often giving way to verbal aggression and anger. His teacher stated that Gilberto was a "big tattler". When this writer would present a sensitive topic, Gilberto would stick his fingers in his ears and in a sing-song manner, repeatedly say, "I can't hear you". Gilberto would get angry at the writer, cry, and shout. However, he never left the therapy room and stayed for the entire session even if it were unpleasant for him. He appeared to be a good candidate for the social competency remediation program.

Gilberto made excellent progress during the implementation of this practicum. Due to the relationship that had already been established, Gilberto was ready to comply with the directives given for the social dilemma drawings. He had no difficulties with recognizing social cues and could appropriately "read" what was transpiring in the drawings presented to him. Initially however, Gilberto found it hard to generate pro-social solutions to the problems as presented. Even when he did come up with something appropriate, he would not draw or commit to it. Instead, Gilberto would talk endlessly about how that particular solution wouldn't work.

To intervene in what seemed like a cyclical pattern of negativity, this writer structured Gilberto's sessions around social themes that required him to take ownership of his behaviors. One of the first steps in the process was to decrease Gilberto's use of talking (arguing and pleading) as a defense against getting to the source of problems. Therefore, this writer acknowledged the "impossibility" of his solutions and agreed that perhaps nothing positive would result from what he had chosen as a solution to a given social dilemma. This immediately cut into his need to argue, defend his case, and become oppositional. However, Gilberto was instructed that he needed to draw a solution to any one of the four given scenarios (more if he wished, but at least one) no matter how improbable it seemed. To accomplish this task, he was presented with an array of two dimensional media and asked to pick one or all of the materials to create his art work. Humor was involved along with relaxation exercises. This method established a beginning towards compliance with solving social situations in a simulated environment. Once Gilberto committed to actually drawing or painting a social situation picture, he would then discuss it in rational, and logical terms. The impossible became possible when graphically portrayed by his own hand. He began to have

fun with the media, stopped arguing, and began to focus on creating art works. Another intervention geared towards reducing opposition was the creation of a list by Gilberto. Gilberto had a number of projects he wanted to create during art therapy. As long as they were geared towards increasing feelings of self-worth (and therefore would improve feelings of competency), this writer assisted him in compiling a list of what he wanted to do. From that point on, Gilberto "took turns" with this writer. One week he would work on his idea and the next, he would be given a directive. List making increased his ability to focus and decreased his impulsivity.

Gilberto made substantial progress during the eight months he participated in this program. Close contact with his teacher and the support of his mother helped. At the conclusion of this practicum, Gilberto no longer put his fingers in his ears or spoke in a sing-song manner during sessions. More importantly, he no longer jumped from one idea to the next and most often remained with an activity until it was completed. All but one of the art products in his folder was finished. His opposition and whining decreased. In the after-school setting, Gilberto received positive reports for his social interactions. Although he would get angry, he was able to control what had been

formerly, aggressive outbursts. In addition, Gilberto showed pride in his graphic achievements and requested that his paintings be put on display. This writer was instrumental in having Gilberto evaluated by the site's psychiatric fellow and having his mother become more actively involved with his therapy by the conclusion of this practicum. An anti-depressant medication has since been recommended. It has taken Gilberto a long time to make these social and emotional developmental gains. This writer feels that this is only the beginning for Gilberto. With support and structure, more developmental gains are expected.

Case Highlights of Charles

Charles, a ten year old boy, was new to the school and the psycho-educational program when he began the social competency remediation with this writer program. Charles was referred to the program for SED children from a Learning Disabilities (LD) classroom. Charles's social history was not conducive to positive developmental growth in his early development. However, almost all of the students in the SED program have a problematic social history but not all are ADHD.

At the onset of this practicum, Charles made little eye

contact. His conversation during individual sessions was limited to either short, choppy sentences or floods of uncontrollable speech. When he did attempt to engage this writer or a peer, his remarks were said in a friendly tone but were rude and insulting. Other children were quick to pick up on his deceptive social encounters and most adults were offended.

Charles appeared to want attention from adults and other children but simply did not know how to engage others in a positive fashion. He would almost topple unsuspecting adults by throwing his arms around them in the guise of giving a "hug". As a result, he received a great deal of negative attention. Positive reinforcements and tangible rewards were not enough to keep him on-task and in his seat.

In play and in therapy, he was often critical of others. He would tease other children and then run from elicited angry responses. Initially this writer had included Charles in a dyad with another socially inept, ADHD peer. However, Charles's tendency to continually make hurtful remarks (especially when delivered in a sweet and friendly tone) was not conducive to fostering positive feelings of self-worth and competency in the other student.

At the onset of this practicum, Charles was unable to

interpret any of the cues in the graphic, social dilemma scenarios presented to him. He appeared not to see frowns on faces, furrowed brows, and clenched fists. Charles found no problems in any of the scenarios he "read". He would state that everything was fine and everyone was happy.

Two months into the social competency remediation program, Charles began taking Ritalin to control his impulsivity in the classroom. His teacher reported more positive, in-seat behaviors but no improvements in the areas of socialization with peers. Medication did not appear to produce any observable changes in his art therapy sessions. Charles's tendency to avoid issues and feelings was the same with or without his medication.

Remediation in the areas of social development started at the very beginning for Charles. Interestingly, Charles was being raised by his grandparents because of his mother's inability to parent responsibly. The grandparents were very protective and fearful of their environment. They did not allow him to associate with neighborhood children. Charles had few opportunities to practice appropriate peer interactions. School, therefore, was the only place for him to increase his social development.

In order to help Charles get in touch with his own

feelings and those of others, this writer created a non-threatening and non-judgmental environment. Charles's art works were accepted and displayed at his request. Confused or "mixed up" feelings depicted in masses of swirled paint became symbolic representations of his inner turmoil. To separate one feeling from another, this writer helped Charles separate one color from another and attach to it, a feeling and meaning. Discussions revolved around talking about when that feeling occurred and what was happening at the time it happened. Role playing also helped Charles identify his feelings and those of others. Although too threatened to deal with real people and real events, Charles spent time accurately identifying feelings of others in specific situations. Charles's need for power was also symbolically represented. Car and truck drawings gave way to large sculptures of pre-historic animals. The animals, created with loving care, were friendly creatures who, in Charles's scenarios, got along well together. In addition, changes in the classroom helped Charles improve his peer interactions. Charles's teacher structured some of his activity time to necessitate sharing and playing with at least, one other student.

Charles's eye contact and ability to stay focused improved. Ego boundaries were observed to have improved.

He no longer made rude remarks to adults and did not spontaneously give adults an unwanted hug. His ability to interpret graphically presented social situations improved. He displayed an ability to generate and depict at least one acceptable solution to a graphically portrayed, social dilemma 4 out of 5 times. It is interesting to note that at the end of this practicum, Charles no longer qualified as a Learning Disabled student. He was on or above grade level in all areas except spelling.

Overshadowing many of Charles's behaviors may have been the question, why? Why did mother not want him? Why did everyone in his home pretend that it was normal and natural to be adopted by grandparents? What was wrong? One step this writer took, was to encourage the family to address this issue honestly with him. Fantasy played a significant role in Charles's life and it was important for him to distinguish between what he could and could not control.

Although Charles made progress in several areas of his social development, this writer felt that Charles was perhaps more depressed and more filled with anxiety than other ADHD students. His fear of rejection, loss, and separation issues needed to be addressed before he could interact with others more positively and significantly increase his feelings of social competency.

Discussion

The program to improve the social competency of ADHD and SED children was beneficial. The children appeared to have gained an awareness of how their behaviors impacted upon others and how to resolve problem areas without resorting to fighting or crying. The classroom teachers also benefited as fewer disruptions made for a more pleasant academic environment. This writer believes that more than academic skills, children with handicapping conditions need to know how to get along with others and how to function productively as a member of society.

It is a strong possibility that expressive therapy offers ADHD students a better alternative to traditional, verbal modes of intervention. This writer also believes that building rapport is one of the most valuable "tools" in the therapeutic environment. Time and patience are needed when working with children who are impulsive, angry, and oppositional. ADHD children often perceive themselves as having no control over themselves or their environment. Giving back control to the child, in a safe and structured environment, allows for the establishment of a working relationship built upon trust. With this in mind, it was not surprising that at the onset of this practicum, the

drawings of students labeled ADHD often proceeded in the following fashion during art therapy sessions. The student would first commence a given drawing activity in an age-appropriate fashion. Then, the student's energy would become fragmented as observed by a progression of haphazard scribbles over what he or she had created. Finally, disappointed and frustrated, the student would tear up the drawing. None of this was done in a quiet fashion. This rapid progression towards regression was accompanied by annoying remarks, yelling and most often, crying. Breaking the cycle of learned, negative behaviors and anticipated reactions was a primary goal in the road towards increased social development. This was accomplished during the implementation of this practicum through building trust, being consistent, and employing a non-judgmental, flexible yet structured attitude.

To help students gain control, increase their frustration tolerance, and feelings of competency, this writer structured the sessions very carefully. Within the boundaries of what is considered a structured environment, there exists room for needed, flexibility, spontaneity, and humor. This writer found that it was helpful to have the students review their personal goals at the beginning of each session. A directed assignment was given but the

child had the option of doing something else as long as the theme remained focused on social interactions.

Flexibility was the "key" when working to change the behavior of oppositional children in the art therapy setting. For example, if the directive was to solve a given social dilemma by drawing an appropriate solution and the child resisted, several options were offered. The child could use the same theme but a different media, or change the social situation to one of his own choosing and still use a drawing medium. Commenting on observations made during sessions was helpful. If increased frustration or regression was noted while a student was creating, the writer would comment upon what was observed. Often the student would ignore what was said. It is important to remember that an oppositional child hears what is spoken but may choose not to respond for a reason. It is this writer's belief that the child's "reason" needs to be respected. Getting angry or demanding compliance is not conducive to facilitating change. What appeared to give the child a sense of control was to ask on another day, how it feels to be ignored. This also provided an opening for discussions about what it means to be ignored and how it feels when left out of an activity by their parents or peers. Feelings of being worthless, alone, and rejected

were significant issues for ADHD students.

Since feelings were so extensively worked upon during this practicum, all of the children in the program were able to reflect on the feelings surrounding rejection accurately. The ability to empathize with others appeared to improve. Each student was able to tell how he or she would feel in a similar situation.

Art media provides many opportunities for frustration and anger and in turn, control of these emotions. Each student improved his or her ability to remain calm even when challenged by the media. A review of their art folders proved to be a positive experience for both the students and this writer.

Although it was not the intent of this practicum, an interesting observation was made by this writer when looking at the results of the children labeled as ADHD and the children labeled as SED but not ADHD. It was observed that those children who were SED often solved social dilemma situations through the use of fantasy. For example, one child chose to solve the problem of a boy being excluded from play by drawing a helicopter taking all the children to Jurasic Park (appendix C). He then drew a detailed version of the park as he remembered it from the movie. When asked about the reality of that solution, the

child became sad and weepy but did not get angry. Children who were labeled, ADHD solved social problems more often with aggression and/or violence. The ADHD children created characters that would yell profanity, use weapons, and/or use fists. At the conclusion of this practicum, ADHD children tended to use a fewer aggressive acts in their art works to solve their problems but the SED children's use of fantasy did not appreciably decrease. Although it is beyond the scope of this practicum to compare the two groups of children serviced in art therapy during this practicum, it is safe to say that those children diagnosed as ADHD did not use fantasy as an escape or as a coping mechanism. They most often solved problems through aggressive, asocial acts whereas SED children used harmless, fantasy oriented methods to resolve conflict.

Another interesting observation, beyond the scope of this practicum, was the degree to which anxiety effects the ADHD child's behaviors. This writer observed a definite difference between those children who were motorically active (hyperactive) and those children who were fidgety and jumpy (anxious). The former appeared to have no known reason for their uncontrolled activity. Whether they had come to a therapy session directly from a quiet, reading period or a highly charged activity, they exhibited the

same degree of high, physical activity. The latter group displayed a correlation between something that had occurred at home or in the classroom and their physical activity. If something had upset or excited them, it was observable in their increased energy level. Since ADHD children have a poor ability to interpret others or their environment accurately, their misperceptions may create undue anxiety for them. To quell their anxiety and in turn, decrease hyperactivity or impulsivity, this writer found that explaining and re-explaining situations over a period of several days was beneficial. Similar to the very young child who needs to have stories and events told over and again until mastery is achieved, and ADHD child may need the same type of repetition to feel comfortable and secure. A sensitivity to the anxiety of some ADHD children and their need for consistent repetition may assist teachers develop more effective strategies for decreasing physical mobility within the classroom.

The inability of the writer's students to transfer their learned, positive social behaviors to other environments may be a function of the severity of their handicapping condition, family turmoil, poor parenting, and conduct disorder components of their disability. Since many of the pro-social behaviors were learned and employed

in structured school activities, the art therapy environment, and in group therapy settings, there exists a potential for transference. As natural maturation proceeds and continued support programs are incorporated into a psychoeducational program for ADHD children many positive pro-social behaviors may transfer to various social situations.

Recommendations

The following recommendations are based upon this writer's research and knowledge gained during the implementation of the social competency program for ADHD and SED children.

1. A continuation of a directed social competency program using expressive therapy in an individual or dyad format.

2. Inservice programs for teachers of handicapped children on social development and how to increase social competency of their students and promote pro-social behaviors in negative children.

3. The establishment of parenting skills training classes in the evenings.

4. Increased community involvement and cooperation

with providing all students additional opportunities to practice learned, pro-social behaviors. Restaurants, museums, and parks could become social training grounds for children who need to improve their social skills.

Dissemination

This writer plans to disseminate the curriculum and discussion portion off this practicum to other expressive therapists in the area. The state chapter of the American Art Therapy Association has also expressed interest in having this information presented at the state conference next year. If published this practicum could reach a much larger audience and perhaps assist other professionals with helping socially deficient children improve feelings of social competency.

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APPENDIX A

SAMPLE PERMISSION LETTER

PERMISSION LETTER TO XEROX ARTWORK AND RELEASE OF INFORMATION FORM

Dear Parent or Guardian:

One of your child's artworks has been selected to be included in a written, Doctorate Practicum for Nova University for educational purposes. Information about his experience with Art Therapy may or may not be also included. In order to print the artwork and information, you are asked to sign and return this permission form.

I hereby give permission for the artwork and possible Art Therapy experience of my child, _____, to be duplicated for publication for a written Doctorate Practicum for Nova University.

I understand that I and my child will receive no fees or compensation for this effort. I understand that my child's name will not be used and that confidentiality will be maintained.

Thank you for your help. Your child and I have both enjoyed the Art Therapy sessions.

Sincerely,

Linda Jo Pfeiffer, A.T.R.

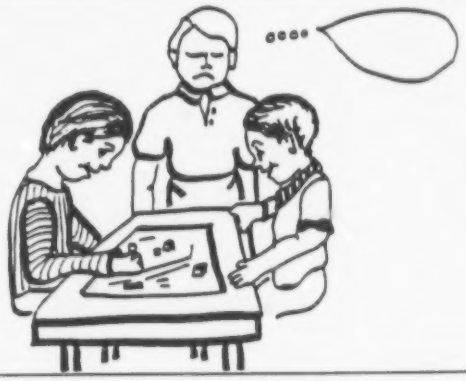
_____ _____

Parent/Guardian Signature

Date

APPENDIX B

SOCIAL DILEMMA DRAWING SAMPLES



GENERATING
SOLUTIONS

THROUGH
SOCIAL DILEMMA
SITUATIONS

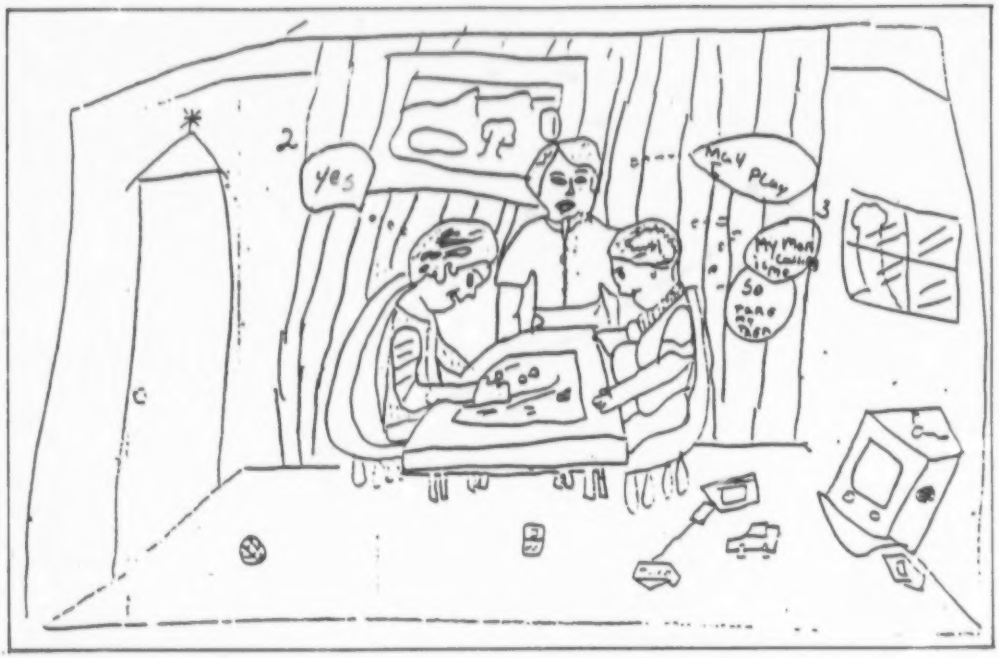
WHAT DO YOU THINK
IS HAPPENING IN
THESE PICTURES

DRAW A POSITIVE
SOLUTION TO THE
SITUATION(S)

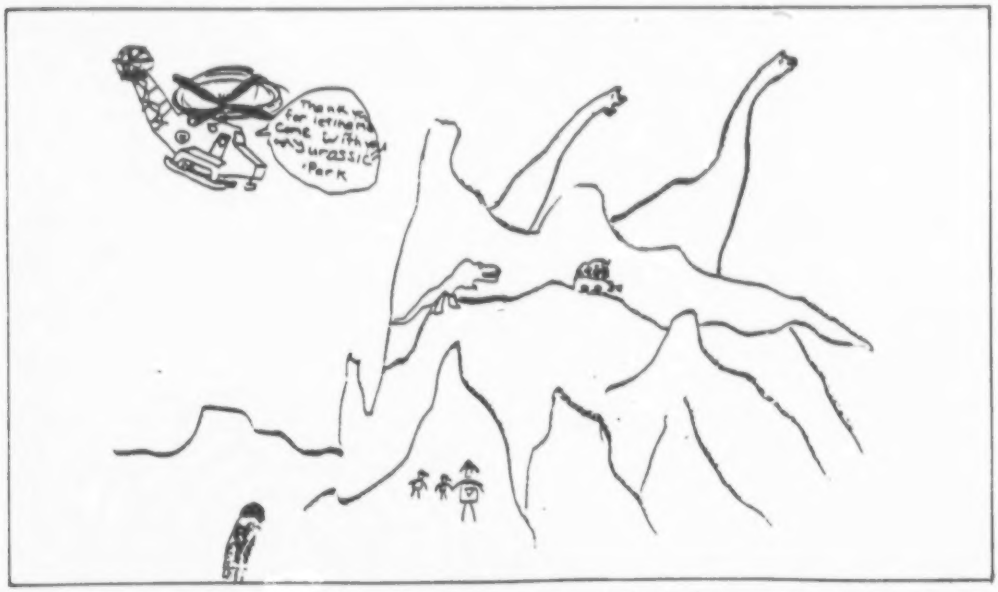
© l.pfeiffer 1993

APPENDIX C

STUDENT DRAWING RESPONSE SAMPLES



Positive solution to social dilemma generated by ADHD student. "May I Play". "Yes". "My mom is calling me so take my turn."



Fantasy solution to dilemma generated by SED student. "A helicopter came and took all three boys to Jurassic Park."

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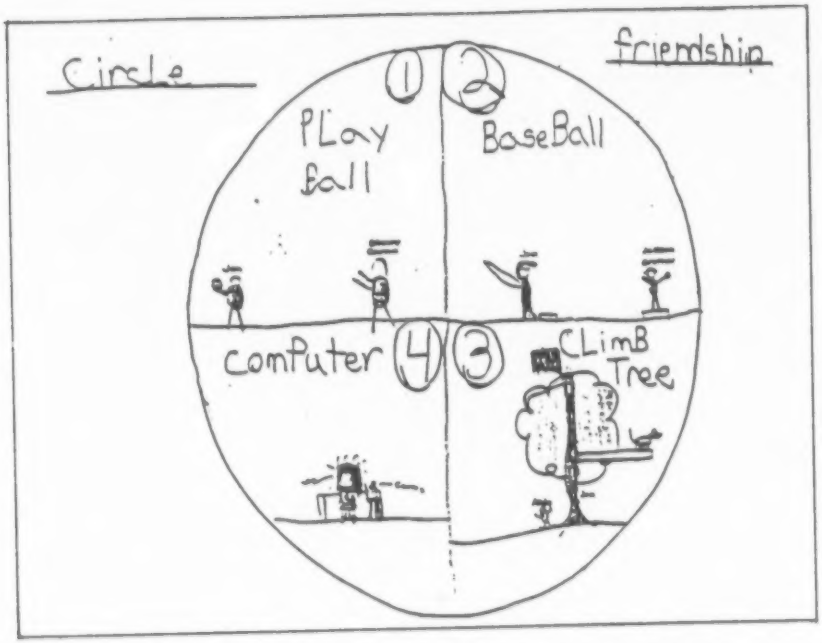
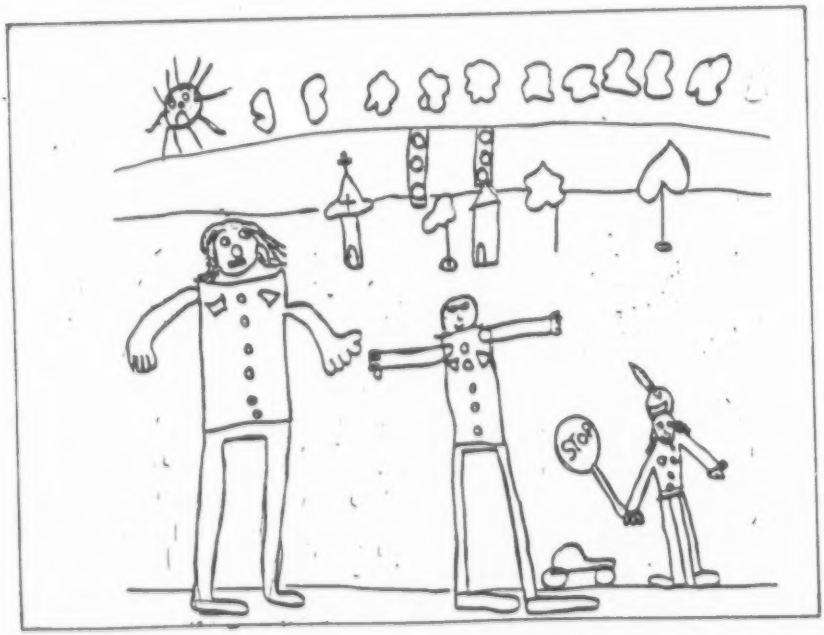


Four Ways I Can Play With a Friend.



Friendship Picture: "Me and My Friend".

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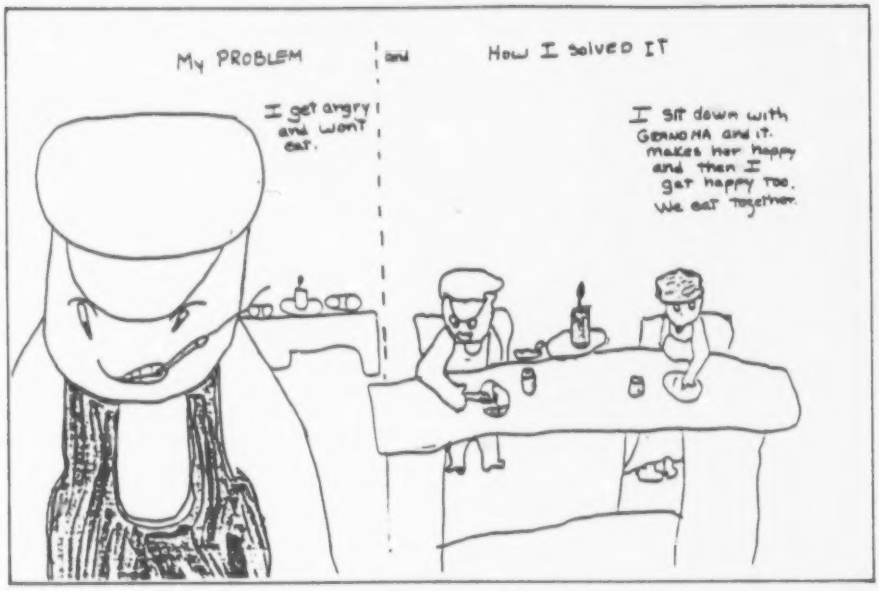
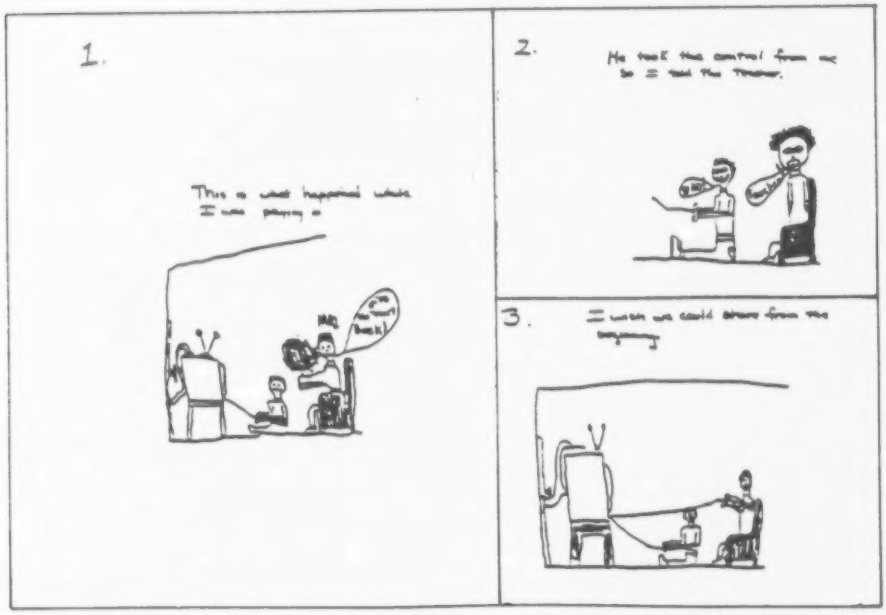

My PROBLEM
and
How I solved IT
I get angry and won't eat.
I sit down with Grandma and it makes her happy and then I get happy too. We eat together.

Solutions to Problems: My Problem and How I Solved It.



Sequential Problem Solving: What Happened? What was the Result? What Did You Wish Had Happened?

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